

To: Health Policy Commission
From: Stephen Slaten, PhD
Re: Testimony on Health Care Cost Trends
Date: October 7, 2013

My name is Stephen Slaten. I am a practicing clinical psychologist, I have run a social service agency, I am Treasurer of Mass Psychological Association. I have been affected by the increasing cost of health benefits as an employer, and by the limits set on mental health care and reimbursement while the price for other specialty care continues to increase.

I serve on Health Care for All's Consumer Advocacy Leadership Team since they took up the issue of impact of shifting greater out of pocket expenses to the consumer to contain premiums.

I submit this testimony as a consumer. I left a job last year and had to pay \$1700 per month to continue my family plan on COBRA. At the time my unemployment benefit, the maximum allowed, was only about \$2500 per month. This was a plan with a \$1000 per person/ \$2000 per family deductible and \$25 co-pays. Fortunately after a while I was eligible for a partial subsidy paid by the state through Unemployment's Medical Security Plan, for which I was reimbursed six weeks later. Without the state, my health would have been compromised and my family's financial health more compromised.

There is good news in CHIA's report on the Massachusetts Health Care Market, and good news trumpeted by CEOs of health care organizations and insurance companies which I attended several weeks ago. All of them reported an undisclosed amount of success in decreasing costs and improving quality of care. And I should be happy that spending by commercial insurance rose only by 3.8% in the last year of figures.

But we consumers have a very different context in which to interpret the data and declare the progress as "not nearly good enough."

That context includes that Massachusetts already has the highest per capita health care spending in the country, and the per capita health care spending of the US dwarfs that of all other countries, most of whom attain better health outcomes than us. If health care had to compete internationally as do cars and electronics, the US health care system would be labeled a "worst buy."

That context also includes the Institute of Medicine's reports that 30% of health care spending is waste in that it doesn't contribute to healthier outcomes. Slower growth in premiums does not sound like it addresses the 30% that we overspend, which isn't supposed to occur in a competitive free market. I'm not sure why Republicans aren't insisting on eliminating corporate waste as vehemently as they do government waste, by insisting on a 30% decrease in our premiums.

This context also includes the information in CHIA's report that the slower growth in commercial premiums from 2009-2011, 9.7%, was also accompanied by a 40% increase in deductibles, a 5.1% decrease in benefit value, during a period of time that the median household income in Massachusetts remained lower than three years ago.

Slaten

That is, subscribers with less money paid slightly higher premiums for higher deductible plans with fewer health benefits. Meanwhile the culprit in the slightly higher premiums continues to be higher prices for health care largely from the more expensive health provider systems. I thought competitive markets were supposed to eliminate or reduce market power of sellers to set prices. Early this year, Forbes announced that nine out of the top ten highest paid professions in the country are in health care.

To supplement CHIA's results, a December 2012 Gallup Poll finds 30% of Americans with private health insurance postponed care because of cost in the past twelve months, and 60% of those for a serious health condition. A 2012 Blue Cross Blue Shield of Massachusetts report finds 17.5% of Massachusetts residents had problems paying medical bills despite health insurance coverage. And SAMHSA's most recent annual report finds over 60% of Americans with a diagnosable mental health condition do not receive any treatment, with the primary reason being cited as the cost of care, both for the insured and the uninsured.

In contrast insurance executives and health economists inform us higher out of pocket costs are good for the health care system; they reduce "moral hazard", the consumers' tendency towards overconsumption of goods and services that are subsidized and lower price. If consumers were given equal voice in the health care reform debate, they would expose moral hazard as at best a limited truth; for consumer the relevant statistic is not the growing % of GDP spent on health care, it is the growing % of our paycheck that is goes to health care spending, both premiums and out of pocket costs.

Citing data as "per capita" expenditures creates the illusion that everyone spends a lot of money on health care. Not true; the average expenditure of 50% of the American population was just \$236 per person, according to the National Institute for Health Care Management, accounting for just 3% of all health care spending while the 5% of the population with the highest spending is responsible for 50% of health care expenditures. Out of pocket costs also occur on a curve, in which the average out of pocket cost \$2200 per year for an employee in the commercial market translates to millions of Americans each spending many thousands of dollars out of pocket.

The cost trends in Massachusetts for the past few years remain unsustainable even several years into the future. We are told that some health provider organizations have market clout to demand higher rates of reimbursement from commercial insurers. Insurers are not representing the public's judgment when they negotiate rates with provider organizations, they have their own interests at heart, they compete for accounts with other health plans in part based on their provider network.

Subscribers/consumers/patients have no idea how much is actually being paid for by their insurance every time they go to the doctor or receive care, especially what the total cost would be for treatment through a different provider or organization. The public believes that Boston teaching hospitals provide excellent care and are worth paying more, but they are not asked to judge if their insurance company should pay 10% or 100% more for care at MGH than their local hospital.

I would like to understand why the health status adjusted TME paid by BCBS to Health Alliance is \$390 but to Atrius is \$506. Why does Tufts pay Atrius an adjusted TME of \$395 while BCBS is paying \$101 higher? Are Health Alliance doctors and Tufts doing something right by keeping medical costs down?

Giving consumers some additional information on cost and quality may not be the right information to make decisions based on value. One has to think like a consumer. For instance, HEDIS measures are not meaningful substitutes for health outcomes particularly if I have a specific health condition or a certain procedure. Similarly saving the insurance company several thousand dollars may not be relevant in choosing between two different health provider organizations for care, especially if the cost (deductible) is the same to me. I might also be willing to pay several hundred dollars more for the expensive facility if I've come to believe I'll get better care. I've prepaid the insurance company thousands of dollars for my health plan so I don't care if I save the insurance company thousands of dollars if it only affects me by lowering my premium by \$1 at renewal time. I need the information that is meaningful and understandable to me, not just the information available to the hospital or insurance company. (Einstein is reputed to have said, "not everything that counts is countable, and not everything that is countable, counts").

For consumers to have an impact on "value" they need real decisions in which they can derive an immediate benefit in terms of their health and/or cost. Here are some examples:

- When faced with a procedure or test, the patient calls up the insurance to learn the options of where to get care and differential average price what the insurance company pays each for that procedure. If the patient chooses one of the lesser expensive alternatives, the insurance company rewards him/her with 25% of the savings from the most expensive care.
- After having a procedure at a facility or hospital, to get the patient to review and question the charges, demand the bill is plain English and reward the patient with 25% of the savings negotiated as a result of his/her efforts.
- In choosing health insurance, if a consumer has a health condition(s) then his/her choice will likely be on the basis of a plan which has: a) good coverage for that condition(s), b) has the right provider(s) in the network, and c) which combination of premium/deductible/copayments yield the lowest estimated costs.

Otherwise, useful information for consumers would be which plan best protects consumer interests by:

- a) Is rated the most consumer-friendly, will call back quickly, will be flexible in considering unique subscriber needs/circumstances (in contrast to rigid adherence to rules, most often deny requests and reject appeals, have most consumer complaints).
- b) Which plan has negotiated the lowest rates with the large health care systems, and how much does this save the subscriber in premium cost (provide information by which consumers can identify a "bargain").

Thank you,



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Health Care for All Consumer Advocacy Leadership Team